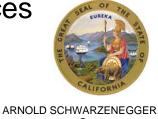
State of California—Health and Human Services Agency



Department of Health Care Services



Governor

QUALITY ASSURANCE FEE FOR THE 2010-11 RATE YEAR

November 16, 2010

Dear Administrator:

This letter provides updated information concerning the Quality Assurance Fee (QAF) assessed for each skilled nursing facility for the rate year, August 1, 2010 to July 31, 2011. California Health and Safety Code, Sections 1324.20 - 1324.30 and Welfare and Institutions Code, Section 14105.06, authorize the Department of Health Care Services (DHCS) to collect a QAF from all non-exempt Free-Standing Skilled Nursing Facilities and Free-Standing Skilled Adult Sub Acute Nursing Facility Level-Bs (FS/NF-Bs). Pursuant to proposed statutory changes (Statutes 2010), the DHCS will be authorized to assess a QAF on multilevel facilities (MLRCs). The purpose of this fee is to enhance federal financial participation in the Medi-Cal program, and to provide additional reimbursement and support for quality improvement efforts in licensed FS/NF-Bs that provide services for the Medi-Cal program.

Effective August 1, 2010, for the rate year 2010-11, DHCS will begin collecting the QAF authorized by the legislature on all SF/NF-Bs, subject to the fee. DHCS will collect the following on a monthly basis:

FS/NF with less than 100,000 total annual resident days – \$13.08 per resident day. FS/NF with equal to or greater than 100,000 total annual resident days - \$11.93 per resident day.

DHCS will send quarterly notices to each facility with three monthly payment forms with the current QAF rate, the payment due date, and the address to mail all payments and forms. Payments are due on or before the last day of the month following the month for which the fee was imposed.

Information about the Long Term Care Reimbursement including provider bulletins is available on the DHCS web site, http://www.dhcs.ca.gov/services/medi-cal/Pages/LTCAB1629.aspx. Information about the QAF program and QAF payment forms are available at the DHCS website, http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

If you have any questions, please contact the Skilled Nursing Facility Quality Assurance Fee Program Coordinator by e-mail at ab1629@dhcs.ca.gov, or by phone at (916) 650-0490.

Sincerely,

Deanna Alvarez, Chief Quality Assurance Fee Unit

DHCS 9103 (11-08)

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 - 2011 (FY) Payment Invoice for AUGUST 1, 2010 to AUGUST 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Development Number:	
National Provider Identifier:	
Due Date:	

Amount Remitted: \$____

Office of Statewide Health Planning and

		Object	Agency	BLK		Agency	PCA		
	Index	Detail	Object	2211	Source	Source	1011	FFY	Fund
	5650	000	00	Н	125600	31	85214	A10	0001
Total Resident Days_		Multiply	by \$13.08 =	Amount Du	ıe				
Original Signature		_							
Print Name			Phone Numb	er		E-Mail			

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the

number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Medicare Advantage, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by \$13.08 and enter that amount in the space provided for the *Amount*

Due

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount

should be the same amount as the Amount Due.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 - 2011 (FY) Payment Invoice for SEPTEMBER 1, 2010 to SEPTEMBER 30, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Development Pumber.	
National Provider Identifier:	
Due Date:	

Office of Statewide Health Planning and

Development Number:

Amount Remitted: \$____

		Object	Agency	BLK		Agency	PCA		
	Index	Detail	Object	2212	Source	Source	1011	FFY	Fund
	5650	000	00	Н	125600	31	85214	A10	0001
Total Resident Days_		Multiply	by \$13.08 =	Amount Du	ıe				
Original Signature			Date			_			
Print Name			Phone Numb	er		E-Mail			

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE - DO NOT CUT IN HALF

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Amount Due - Multiply the *Total Resident Days* by \$13.08 and enter that amount in the space provided for the *Amount*

Due

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount

should be the same amount as the Amount Due.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 - 2011 (FY) Payment Invoice for OCTOBER 1, 2010 to OCTOBER 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Development Number:	
National Provider Identifier:	
Due Date:	

Amount Remitted: \$____

Office of Statewide Health Planning and

		Object	Agency	BLK		Agency	PCA		
	Index	Detail	Object	2212	Source	Source	1011	FFY	Fund
	5650	000	00	Н	125600	31	85214	A10	0001
Total Resident Days_		Multiply	by \$13.08 =	Amount Du	ıe				
Original Signature			Date			_			
Print Name			Phone Numb	er		E-Mail			

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE - DO NOT CUT IN HALF

Payment Invoice Instructions:

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Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

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Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for November 1, 2010 to November 30, 2010

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name:						Office of Sta Number: National I Due Date			
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	Н	125600	31	85214	A10	0001
Total Resident Days		Multiply	y by \$13.08 =	Amount D	ue				
Original Signature			Date						
Print Name			Phone Numb	er		E-Mail			
	PLEAS	SE SUBMIT	THE ENTIRE	E PAYMEN	T INVOICE	– DO NOT CU	J T IN HAI	LF	
Payment Invoice Instr	ructions:								
Total Resident Days -	numbe Bed H	er of days in Iold Days, M	which a patie Iedi-Cal Fee-f	nt resides a or-Service,	nt the skilled , Medi-Cal M		ty. This ir Medicare	ncludes, bu e, Health M	nt days are the at is not limited to Iaintenance
Amount Due -	Multip Due.	oly the Total	Resident Day	s by \$13.0	8 and enter the	hat amount in	the space	provided f	for the Amount
Amount Remitted -			of the check o			sending with t	his payme	nt invoice.	This amount
Original Signature -	Sign ii	n the space p	provided. Plea	ase use ink					
Date -	Enter	the date you	completed th	is payment	invoice.				
Phone Number/E-Mail	- Enter	your area co	de, daytime p	hone numb	er, and E-Ma	ail address.			

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for December 1, 2010 to December 31, 2010

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name:				_					
Address:	Mational Provider Due Date: 1/31/20 Due D	rovider I	dentifier:						
				-		Due Date:	1/31/20	11	
	Index			Due Date: 1/31/2011 Agency PCA Source Source FFY F H 125600 31 85214 A10	Fund				
	5650	000	00	Н	125600	31	85214	A10	0001
Total Resident Days		Multiply	by \$13.08 =	Amount D	ue				
Original Signature			Date						
Print Name			Phone Number	er		E-Mail _			
	PLEAS	SE SUBMIT	THE ENTIRE	PAYMEN	T INVOICE	– DO NOT CU	T IN HAI	. F	
Payment Invoice Instr	uctions:								
Total Resident Days -	numbe Bed H	er of days in old Days, M	which a patie edi-Cal Fee-f	nt resides a or-Service,	nt the skilled , Medi-Cal M	nursing facilit Ianaged Care,	y. This ir Medicare	ncludes, bu , Health M	t is not limited to
Amount Due -	Multip Due.	oly the <i>Total</i>	Resident Day	s by \$13.0	8 and enter tl	hat amount in	the space	provided f	or the Amount
Amount Remitted -				•	-	sending with th	nis payme	nt invoice.	This amount
Original Signature -	Sign in	n the space p	rovided. Plea	ise use ink.					
Date -	Enter t	the date you	completed thi	s payment	invoice.				
Phone Number/E-Mail	- Enter	your area co	de, daytime pl	hone numb	er, and E-Ma	ail address.			

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Office of Statewide Health Planning and Development

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee -2010-2011 (FY) Payment Invoice for January 1, 2011 to January 31, 2011

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name:						Number: National F			
Address:				-					
				_		Due Date:	2/28/20	11	
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	Н	125600	31	85214	A10	0001
Total Resident Days		Multiply	by \$13.08 =	Amount D	ue				
Original Signature			Date						
Print Name			Phone Numb	er		E-Mail			
	PLE	ASE SUBMI	T THE ENTII	RE PAYME	ENT INVOIC	E – DO NOT (CUT IN HA	ALF	
Payment Invoice Inst	ructions:								
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Amount Due -	Multip	oly the Total	Resident Day	s by \$13.0	8 and enter t	hat amount in	the space	provided f	for the Amount Due.
Amount Remitted -			of the check of the as the <i>Amor</i>	•	rder you are s	sending with the	his payme	nt invoice.	This amount should
Original Signature -	Sign ii	n the space p	provided. Plea	ase use ink	•				
Date -	Enter	the date you	completed th	is payment	invoice.				

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

DHCS 9116 (Rev. 02-10)

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for February 1, 2011 to February 28, 2011

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name:						Office of Statewide Health Planning and Developme Number: National Provider Identifier:					
				-		Due Date:	: 03/31/2	2011			
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund		
	5650	000	00	Н	125600	31	85214	A10	0001		
Total Resident Days		Multiply	y by \$13.08 =	Amount D	ue						
Original Signature			Date								
Print Name			Phone Numb	er		E-Mail _					
	PLEAS	SE SUBMIT	THE ENTIRE	E PAYMEN	T INVOICE	– DO NOT CU	T IN HAI	.F			
Payment Invoice Instr	ructions:										
Total Resident Days -	numbe Bed H	Enter the <i>Total Resident Days</i> for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.									
Amount Due -	Multip Due.	oly the <i>Total</i>	Resident Day	s by \$13.0	8 and enter the	hat amount in	the space	provided for	or the Amount		
Amount Remitted -			of the check of amount as the			sending with th	nis payme	nt invoice.	This amount		
Original Signature -	Sign ii	n the space p	provided. Plea	ase use ink							
Date -	Enter	the date you	completed the	is payment	invoice.						
Phone Number/E-Mail	- Enter	Enter your area code, daytime phone number, and E-Mail address.									

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for March 1, 2011 to March 31, 2011

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name:				_		Office of Statewide Health Planning and Developmer Number:					
Address:						National P	rovider I	dentifier:			
				-		Due Date:	4/30/20	11			
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund		
	5650	000	00	Н	125600	31	85214	A10	0001		
Total Resident Days		Multiply	by \$13.08 =	Amount D	ue						
Original Signature			Date			_					
Print Name		Phone Number				E-Mail					
	PLEAS	SE SUBMIT	THE ENTIRE	PAYMEN	T INVOICE	– DO NOT CU	T IN HAL	. F			
Payment Invoice Instr	uctions:										
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Amount Due -	Multip Due.	oly the <i>Total</i>	Resident Day	s by \$13.0	8 and enter tl	hat amount in	the space	provided f	or the Amount		
Amount Remitted -			of the check or e amount as th	•	-	sending with th	nis payme	nt invoice.	This amount		
Original Signature -	Sign in	n the space p	rovided. Plea	ise use ink.							
Date -	Enter t	the date you	completed thi	is payment	invoice.						
Phone Number/E-Mail	- Enter	your area co	de, daytime pl	hone numb	er, and E-Ma	ail address.					

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Office of Statewide Health Planning and Development

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee -2010-2011 (FY) Payment Invoice for April 1, 2011 to April 30, 2011

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name:	_										
Address:				-		National F	dentifier:				
				-		Due Date:	5/31/20	11			
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund		
	5650	000	00	Н	125600	31	85214	A10	0001		
Total Resident Days		Multiply	by \$13.08 =	Amount D	ue						
Original Signature			Date								
Print Name		Phone Numbe			r E-Mail						
	PLE	ASE SUBMI	T THE ENTII	RE PAYME	ENT INVOIC	E – DO NOT (CUT IN HA	ALF			
Payment Invoice Inst	ructions:										
Total Resident Days -	numbe Hold l	Enter the <i>Total Resident Days</i> for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.									
Amount Due -	Multip	oly the Total	Resident Day	s by \$13.0	8 and enter the	hat amount in	the space	provided f	For the Amount D	ue.	
Amount Remitted -			of the check ont as the <i>Amou</i>	•	der you are s	sending with the	his payme	nt invoice.	This amount sh	iould	
Original Signature -	Sign i	Sign in the space provided. Please use ink.									

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

DHCS 9116 (Rev. 02-10)

Date -

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for May 1, 2011 to May 31, 2011

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name: Address:						Office of Statewide Health Planning and Developm Number: National Provider Identifier: Due Date: 06/30/2011				
				_		Due Duice	00/30/2011			
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund	
	5650	000	00	Н	125600	31	85214	A10	0001	
Total Resident Days		Multiply	y by \$13.08 =	Amount D	ue					
Original Signature			Date							
Print Name			Phone Numb	er		E-Mail				
	PLEAS	SE SUBMIT	THE ENTIRE	E PAYMEN	T INVOICE	– DO NOT CU	T IN HAI	LF		
Payment Invoice Inst	ructions:									
Total Resident Days -	numbe Bed H	Enter the <i>Total Resident Days</i> for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.								
Amount Due -	Multip Due.	oly the Total	Resident Day	s by \$13.0	8 and enter t	hat amount in	the space	provided f	or the Amount	
Amount Remitted -			of the check o			sending with th	nis payme	ent invoice.	This amount	
Original Signature -	Sign i	n the space p	provided. Plea	ase use ink	•					
Date -	Enter	the date you	completed th	is payment	invoice.					
Phone Number/E-Mail	- Enter	Enter your area code, daytime phone number, and E-Mail address.								

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for June 1, 2011 to June 30, 2011

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name:				_		Office of Statewide Health Planning and Developmer Number:					
Address:						National P	rovider I	dentifier:			
				-		Due Date:	7/30/2011				
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund		
	5650	000	00	Н	125600	31	85214	A10	0001		
Total Resident Days		Multiply	by \$13.08 =	Amount D	ue						
Original Signature			Date								
Print Name			Phone Number	er		E-Mail					
	PLEAS	SE SUBMIT	THE ENTIRE	PAYMEN	T INVOICE	– DO NOT CU	T IN HAL	. F			
Payment Invoice Instr	uctions:										
Total Resident Days -	numbe Bed H	Enter the <i>Total Resident Days</i> for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.									
Amount Due -	Multip Due.	ly the <i>Total</i>	Resident Day	s by \$13.0	8 and enter tl	hat amount in	the space	provided f	or the Amount		
Amount Remitted -			of the check or e amount as th	•	-	sending with th	nis payme	nt invoice.	This amount		
Original Signature -	Sign in	the space p	rovided. Plea	ise use ink.							
Date -	Enter t	he date you	completed thi	s payment	invoice.						
Phone Number/E-Mail	- Enter	Enter your area code, daytime phone number, and E-Mail address.									

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Office of Statewide Health Planning and Development

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – 2010 – 2011 (FY) Payment Invoice for July 1, 2011 to July 31, 2011

Department of Health Care Services Accounting Section/Cashiers Unit, Mail Stop 1101 1501 Capitol Avenue, Suite 71.2048 P.O. Box 997415 Sacramento, CA 95899-7415

Facility Name:	_									
Address:				_		National F	Provider l	dentifier:		
				-		Due Date:	8/31/20	11		
	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund	
	5650	000	00	Н	125600	31	85214	A10	0001	
Total Resident Days_		Multiply	by \$13.08 =	Amount D	ue					
Original Signature			Date							
Print Name Phone Number			er	E-Mail						
	PLE	ASE SUBMI	T THE ENTIR	RE PAYME	ENT INVOIC	E – DO NOT (CUT IN HA	ALF		
Payment Invoice Inst	tructions:									
Total Resident Days -	numbe Hold I	er of days in Days, Medi-	which a patie Cal Fee-for-S	nt resides a ervice, Me	at the skilled di-Cal Mana	nursing facilit	y. This in	ncludes, bu	nt days are the t is not limited to Be enance Organization	
Amount Due -	Multip	oly the <i>Total</i>	Resident Day	s by \$13.0	8 and enter the	hat amount in	the space	provided f	or the Amount Due.	
Amount Remitted -			of the check on the as the Amor	•	der you are s	sending with the	his payme	nt invoice.	This amount shoul	d
Original Signature -	Sign i	n the space p	rovided. Plea	ase use ink						

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

DHCS 9116 (Rev. 02-10)

Date -